AMERICAN NATIONAL STANDARDS INSTITUTE (ANSI)

CLAIM ADJUSTMENT REASON CODES

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 266-3585
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Code	Definition
1	Deductible amount
2	Coinsurance amount
3	Copayment amount
4	The procedure code is inconsistent with the modifier used or a required modifier is missing
5	The procedure code/bill type is inconsistent with the place of service
6	The procedure/revenue code is inconsistent with the patient's age *(changed as of 6/02)*
7	The procedure/revenue code is inconsistent with the patient's gender *(changed as of 6/02)*
8	The procedure code is inconsistent with the provider type/specialty (taxonomy) *(changed as of 6/02)*
9	The diagnosis is inconsistent with the patient's age
10	The diagnosis is inconsistent with the patient's gender *(changed as of 2/00)*
11	The diagnosis is inconsistent with the procedure
12	The diagnosis is inconsistent with the provider type
13	The date of death precedes the date of service
14	The date of birth follows the date of service
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider *(changed as of 2/01)*
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate *(changed as of 2/02)*
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using remittance advice remarks codes whenever appropriate *(changed as of 2/02)*
18	Duplicate claim/service
19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation carrier
20	Claim denied because this injury/illness is covered by the liability carrier
21	Claim denied because this injury/illness is the liability of the no-fault carrier
22	Payment adjusted because this care may be covered by another payer per coordination of benefits *(changed as of 2/01)*
23	Payment adjusted because charges have been paid by another payer *(changed as of 2/01)*
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan *(changed as of 6/00)*
25	Payment denied—your stop loss deductible has not been met
26	Expenses incurred prior to coverage
27	Expenses incurred after coverage terminated
28	Coverage not in effect at the time the service was provided *(Inactive for 004010 since 6/98. Redundant to codes 26 and 27.)*
29	The time limit for filing has expired
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting or residency requirements *(changed as of 2/01)*
31	Claim denied as patient cannot be identified as our insured
32	Our records indicate that this dependent is not an eligible dependent as defined
33	Claim denied—insured has no dependent coverage
34	Claim denied. Insured has no coverage for newborns
35	Lifetime benefit maximum has been reached *(changed as of 10/02)*

* = Inactive for 003040.
^ = Inactive for 003050.
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o = Inactive for 004010 since 2/99. Use code 16 and remark codes if necessary.
♦ = Inactive for 003070 since 8/97. Use code 17.

Code	Definition
*36	Balance does not exceed copayment amount
*37	Balance does not exceed deductible
38	Services not provided or authorized by designated (network/primary care) providers *(changed as of 6/03)*
39	Services denied at the time authorization/precertification was requested
40	Charges do not meet qualifications for emergent/urgent care
*41	Discount agreed to in Preferred Provider contract
42	Charges exceed our fee schedule or maximum allowable amount
43	Gramm-Rudman reduction
44	Prompt-pay discount
45	Charges exceed your contracted/legislated fee arrangement
46	This (these) service(s) is (are) not covered *(Inactive for 004010 since 6/00. Use code 96.)*
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid *(changed as of 6/00)*
48	This (these) procedure(s) is (are) not covered *(Inactive for 004010 since 6/00. Use code 96.)*
49	These are noncovered services because this is a routine exam or screening procedure done in conjunction with a routine exam
50	These are noncovered services because this is not deemed a "medical necessity" by the payer
51	These are noncovered services because this is a preexisting condition
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed *(changed as of 10/98)*
53	Services by an immediate relative or a member of the same household are not covered
54	Multiple physicians/assistants are not covered in this case
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer
56	Claim/service denied because procedure/treatment has not been deemed "proven to be effective" by the payer
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply *(Inactive for 004050. Split into codes 150, 151, 152, 153, and 154.)*
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service *(changed as of 2/01)*
59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules *(changed as of 6/00)*
60	Charges for outpatient services with this proximity to inpatient services are not covered
61	Charges adjusted as penalty for failure to obtain second surgical opinion *(changed as of 6/00)*
62	Payment denied/reduced for absence of, or exceeded, precertification/authorization *(changed as of 2/01)*
*63	Correction to a prior claim
*64	Denial reversed per Medical Review
*65	Procedure code was incorrect—this payment reflects the correct code
66	Blood deductible
*67	Lifetime reserve days *(handled in QTY, QTY01=LA)*
*68	DRG weight *(handled in CLP12)*
69	Day outlier amount
70	Cost outlier—Adjustment to compensate for additional costs *(changed as of 6/01)*
71	Primary payer amount *(Deleted as of 6/00. Use code 23.)*
*72	Coinsurance day *(handled in QTY, QTY01=CD)*
^73	Administrative days
74	Indirect medical education adjustment
75	Direct medical education adjustment
76	Disproportionate share adjustment

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*77	Covered days *(handled in QTY, QTY01=CA)*
78	Noncovered days/room charge adjustment
^79	Cost report days *(handled in MIA15)*
^80	Outlier days *(handled in QTY, QTY01=OU)*
*81	Discharges
*82	PIP days
*83	Total visits
^84	Capital adjustment *(handled in MIA)*
85	Interest amount
86	Statutory adjustment *(Inactive for 004010 since 6/98. Duplicate of code 45.)*
87	Transfer amount
88	Adjustment amount represents collection against receivable created in prior overpayment *(Inactive for 004050.)*
89	Professional fees removed from charges
90	Ingredient cost adjustment
91	Dispensing fee adjustment
*92	Claim paid in full
93	No claim level adjustments *(Inactive for 004010 since 2/99. In 004010, CAS at the claim level is optional.)*
94	Processed in excess of charges
95	Benefits adjusted. Plan procedures not followed *(changed as of 6/00)*
96	Noncovered charge(s)
97	Payment is included in the allowance for another service/procedure *(changed as of 2/99)*
*98	The hospital must file the Medicare claim for this inpatient nonphysician service
*99	Medicare secondary payer adjustment amount
100	Payment made to patient/insured/responsible party
101	Predetermination: anticipated payment upon completion of services or claim adjudication *(changed as of 2/99)*
102	Major medical adjustment
103	Provider promotional discount (e.g., senior citizen discount) *(changed as of 6/01)*
104	Managed care withholding
105	Tax withholding
106	Patient payment option/election not in effect
107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on the claim *(changed as of 6/03)*
108	Payment adjusted because rent/purchase guidelines were not met *(changed as of 6/02)*
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor
110	Billing date predates service date
111	Not covered unless the provider accepts assignment
112	Payment adjusted as not furnished directly to the patient and/or not documented *(changed as of 2/01)*
113	Payment denied because service/procedure was provided outside the United States or as a result of war *(Changed as of 2/01. Inactive for version 004060. Use codes 157, 158, or 159.)*
114	Procedure/product not approved by the Food and Drug Administration
115	Payment adjusted as procedure postponed or canceled *(changed as of 2/01)*
116	Payment denied. The advance indemnification notice signed by the patient did not comply with requirements *(changed as of 2/01)*
117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care *(changed as of 2/01)*
118	Charges reduced for ESRD network support
119	Benefit maximum for this time period or occurrence has been reached *(changed as of 2/04)*

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Code	Definition
120	Patient is covered by a managed care plan *(Inactive for 004030 since 6/99. Use code 24.)*
121	Indemnification adjustment
122	Psychiatric reduction
□123	Payer refund due to overpayment
□124	Payer refund amount—not our patient
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using remittance advice remarks codes whenever appropriate *(changed as of 2/02)*
126	Deductible—Major Medical *(new as of 2/97)*
127	Coinsurance—Major Medical *(new as of 2/97)*
128	Newborn's services are covered in the mother's allowance *(new as of 2/97)*
129	Payment denied. Prior processing information appears incorrect *(changed as of 2/01)*
130	Claim submission fee *(changed as of 6/01)*
131	Claim specific negotiated discount *(new as of 2/97)*
132	Prearranged demonstration project adjustment *(new as of 2/97)*
133	The disposition of the claim/service is pending further review *(changed as of 10/99)*
134	Technical fees removed from charges *(new as of 10/98)*
135	Claim denied. Interim bills cannot be processed *(new as of 10/98)*
136	Claim adjusted. Plan procedures of a prior payer were not followed *(changed as of 6/00)*
137	Payment/reduction for regulatory surcharges, assessments, allowances or health related taxes *(new as of 2/99)*
138	Claim/service denied. Appeal procedures not followed or time limits not met *(new as of 6/99)*
139	Contracted funding agreement—subscriber is employed by the provider of services *(new as of 6/99)*
140	Patient/insured health identification number and name do not match *(new as of 6/99)*
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage *(changed as of 6/00)*
142	Claim adjusted by the monthly Medicaid patient liability amount *(new as of 6/00)*
143	Portion of payment deferred *(new as of 2/01)*
144	Incentive adjustment, e.g., preferred product/service *(new as of 6/01)*
145	Premium payment withholding *(new as of 6/02)*
146	Payment denied because the diagnosis was invalid for the date(s) of service reported *(new as of 6/02)*
147	Provider contracted/negotiated rate expired or not on file *(new as of 6/02)*
148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete *(new as of 6/02)*
149	Lifetime benefit maximum has been reached for this service/benefit category *(new as of 10/02)*
150	Payment adjusted because the payer deems the information submitted does not support this level of service *(new as of 10/02)*
151	Payment adjusted because the payer deems the information submitted does not support this many services *(new as of 10/02)*
152	Payment adjusted because the payer deems the information submitted does not support this length of service *(new as of 10/02)*
153	Payment adjusted because the payer deems the information submitted does not support this dosage *(new as of 10/02)*
154	Payment adjusted because the payer deems the information submitted does not support this day's supply *(new as of 10/02)*
155	This claim is denied because the patient refused the service/procedure *(new as of 6/03)*
156	Flexible spending account payments *(new as of 9/03)*
157	Payment denied/reduced because the service/procedure was provided as a result of an act of war *(new as of 9/03)*
158	Payment denied/reduced because the service/procedure was provided outside of the United States *(new as of 9/03)*

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159	Payment denied/reduced because the service/procedure was provided as a result of terrorism *(new as of 9/03)*
160	Payment denied/reduced because the injury/illness was the result of an activity that is a benefit exclusion *(new as of 9/03)*
161	Provider performance bonus *(new as of 2/04)*
162	State-mandated requirement for Property and Casualty. See Claim Payment Remarks Code for specific explanation *(new as of 2/04)*
163	Claim/Service adjusted because the attachment referenced on the claim was not received *(new as of 6/04)*
164	Claim/Service adjusted because the attachment referenced on the claim was not received in a timely fashion *(new as of 6/04)*
A0	Patient refund amount
A1	Claim denied charges
A2	Contractual adjustment *(Inactive for 004060. Use code 45 with Group Code "CO" or use another appropriate specific adjustment code.)*
A3	Medicare secondary payer liability met *(Inactive for 004010 since 6/98.)*
A4	Medicare claim PPS capital day outlier amount
A5	Medicare claim PPS capital cost outlier amount
A6	Prior hospitalization or 30-day transfer requirement not met
A7	Presumptive payment adjustment
A8	Claim denied; ungroupabe DRG
B1	Noncovered visits
*B2	Covered visits
*B3	Covered charges
B4	Late filing penalty
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded *(changed as of 2/01)*
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty *(changed as of 2/01)*
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service *(changed as of 10/98)*
B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized
B9	Services not covered because the patient is enrolled in a Hospice
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor
B12	Services not documented in patients' medical records
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment
B14	Payment denied because only one visit or consultation per physician per day is covered *(changed as of 2/01)*
B15	Payment adjusted because this procedure/service is not paid separately *(changed as of 2/01)*
B16	Payment adjusted because "New Patient" qualifications were not met *(changed as of 2/01)*
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current *(changed as of 2/01)*
B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission *(changed as of 2/01)*
B19	Claim/service adjusted because of the finding of a Review Organization *(Inactive for 003070.)*

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B20	Payment adjusted because procedure/service was partially or fully furnished by another provider *(changed as of 2/01)*
*B21	The charges were reduced because the service/care was partially furnished by another physician
B22	This payment is adjusted based on the diagnosis *(changed as of 2/01)*
B23	Payment denied because this provider has failed an aspect of a proficiency testing program *(changed as of 2/01)*
⚬D1	Claim/service denied. Level of subluxation is missing or inadequate
⚬D2	Claim lacks the name, strength, or dosage of the drug furnished
⚬D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing
⚬D4	Claim/service does not indicate the period of time for which this will be needed
⚬D5	Claim/service denied. Claim lacks individual lab codes included in the test
⚬D6	Claim/service denied. Claim did not include patient's medical record for the service
⚬D7	Claim/service denied. Claim lacks date of patient's most recent physician visit
⚬D8	Claim/service denied. Claim lacks indicator that "x-ray is available for review"
⚬D9	Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used
♦D10	Claim/service denied. Completed physician financial relationship form not on file
♦D11	Claim lacks completed pacemaker registration form
♦D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test
♦D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest
♦D14	Claim lacks indication that plan of treatment is on file
♦D15	Claim lacks indication that service was supervised or evaluated by a physician
W1	Workers compensation state fee schedule adjustment *(new as of 2/00)*

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